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4. PROGRAM REGULATIONS

414.401: Introduction

The regulations in 130 CMR 414.000 state the requirements for the reimbursement of nursing services provided by an independent nurse participating in MassHealth. These regulations apply to nurses who contract independently with MassHealth.

414.402: Definitions

The following definitions used in 130 CMR 414.000 have the meanings given in this section unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 414.402 is not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 414.000 and in 130 CMR 450.000.

Calendar Week — seven consecutive days.

Case Manager — a registered nurse employed by the Division or its designee to provide case management to complex-care members, to work cooperatively with that member, his or her family and primary caregiver(s), and all relevant providers.

Clinical Criteria — professionally recognized health-care need standards by which the Division or its designee determines the medical necessity for nursing services.

Clinical Outcome — the consequence of nursing intervention.

Community Long-Term-Care (CLTC) Services — certain MassHealth-covered services intended to enable a complex-care member to remain in the community which include, but are not limited to, home health, durable medical equipment, oxygen and respiratory equipment, personal-care attendant, and other health-related services as determined by the Division or its designee.

Complex-Care Member — a MassHealth member, under the age of 22 at enrollment, whose medical needs, as determined by the Division or its designee, are such that he or she requires a nurse encounter of more than two continuous hours of nursing services to remain in the community.

Data Base — a component of the health-care record, the data base is the sum total of all health-related information about the member (for example, the data base includes medical and nursing-care histories as well as physician physical examination and nursing-assessment results).

Emergency — the unexpected onset of symptoms or a condition requiring immediate medical or surgical care, including, but not limited to, heart attack, stroke, poisoning, convulsions, loss of consciousness, and cessation of breathing.

Health-Care Record — a collection of data that includes biographical information and the data base related to the member.

Health-Care Team — a group of individuals with various professional skills who work together, with the member, toward a common health-care goal.

Household Members — individuals who dwell as a single family under the same roof.

Independent Nurse — a nurse who independently enrolls as a provider in MassHealth to provide specialized nursing services, the administration of which require an encounter with a member for more than two continuous hours.

Medical Standards — professionally recognized standards of health care.

Member — an individual determined by the Division to be eligible for MassHealth.

Member Teaching Needs — health-care information required by a MassHealth member or household members, or both, necessary for the promotion, restoration, and maintenance of a member's optimal health status.

Nurse — a person licensed as a registered nurse, a licensed practical nurse, or a licensed vocational nurse by a state's board of registration in nursing.

Nursing-Care Plan — a component of the health-care record, a plan for nursing intervention designed to meet the needs of the member identified in the nursing-care problem list.

Nursing-Care Problem List — a component of the health-care record, obtained from the data base and consisting of the member's clinical needs for intervention by a nurse.

Nursing Progress Notes — a component of the health-care record, the dated notes coincide with the nursing-care problem list and indicate the outcome of nursing intervention.

Nursing Services — the planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse.

Primary Caregiver — the individual, other than the nurse, home health aide, or personal-care worker, who is primarily responsible for providing ongoing care to the member.

Recordkeeping Requirement — member health-care record documentation required by the Division or its designee.

Request and Justification Form — the form (paper, electronic, or other) authorized by the Division or its designee, on which the nursing-care needs of the member, other than a complex-care member, as identified in the screening are described by the provider. This form is submitted to the Division or its designee with the request for prior authorization for nursing services.

414.403: Eligible Members

(A) (1) MassHealth Members. The Division covers nursing services provided by independent nurses only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

414.404: Provider Eligibility

The Division pays for nursing services furnished by an independent nurse who:

(A) is licensed as a nurse by the board of registration in nursing for the state in which the nursing services are provided; and

(B) signs a MassHealth provider agreement and is assigned a MassHealth provider number. The Division does not reimburse an independent nurse for nursing services provided before the nurse signs a MassHealth provider agreement and obtains a MassHealth provider number.

(130 CMR 414.405 through 414.407 Reserved)

414.408: Clinical Criteria for Services

(A) The Division pays for nursing services based only on the nursing care needs of the member and not on the availability or unavailability of the member's family or primary caregiver, except under the circumstances described at 130 CMR 414.409(L)(2) and 414.416.

(B) For nursing services to be authorized, there must be a clearly identifiable, specific medical need for nursing services that requires a nursing encounter of more than two continuous hours in duration. The Division or its designee approves the amount of nursing services based on the level of skilled nursing care determined by the Division or its designee to be medically necessary for the member. Nursing services are reimbursable only if all of the following conditions are met:

(1) the services are ordered by the physician;

(2) the services are medically necessary to treat an illness or injury in accordance with 130 CMR 414.409(D); and

(3) prior authorization is obtained where required in compliance with 130 CMR 414.412.

414.409: Conditions of Coverage

(A) Place of Service. The Division does not pay for nursing services when provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or any other institutional health-care or custodial-care facility. Only those members who require and who are authorized to receive nursing services in the home may receive those services outside the home during those hours when the member's normal life activities take him or her outside the home.

(B) Service Limitation. The Division does not pay an independent nurse for a nursing encounter of less than two continuous hours in duration.

(C) Limit of Hours. The Division does not pay an independent nurse for more than 60 hours of nursing in a calendar week.

(D) Medical Necessity Requirement. In accordance with 130 CMR 450.204, the Division pays for only those nursing services that are medically necessary.

(E) Continuous Nursing. The member must have a medical condition requiring continuous skilled nursing care that includes documentation of assessment, intervention, the teaching of the member and/or family members or other caregivers who are caring for the member, and evaluation of clinical outcomes.

(F) Members for Whom Services Are Approved. The Division does not pay for nursing services provided to any individual other than the member who is eligible to receive such services and for whom such services have been approved by the Division or its designee.

(G) Caregivers Who Are Relatives. The Division does not pay for nursing services when such services are provided by the member's immediate relative defined as: spouse, natural parent, foster parent, child, foster child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandparent, or grandchild.

(H) Availability of Other Caregivers. When a family member or other caregiver is providing services that adequately meet the member's needs, it is not medically necessary for an independent nurse to furnish such services.

(I) Least Costly Form of Care. The Division pays for nursing services only when services are no more costly than medically comparable care in an appropriate institution and the least costly form of comparable care available in the community.

(J) Maintained Safely in the Community. The member's physician and independent nurse must determine that the member can be maintained safely in the community.

(K) Prior Authorization. Nursing services provided by an independent nurse require prior authorization. See 130 CMR 414.412 for requirements.

(L) Maximum Nursing Hours.

(1) A member may be eligible for up to a maximum of 112 hours of nursing services per calendar week if he or she meets the criteria for nursing services as stated in 130 CMR 414.408.

(2) Members may be eligible on a short-term basis, not to exceed three months, for nursing services over the maximum amount if such additional services are determined to be medically necessary by the Division or its designee, and at least one of the following criteria is met:

(a) the member's physician has submitted a determination in writing that the death of the member will likely occur within three months and a request has been made that the member be permitted to die at home;

(b) the member has repeated, acute exacerbations of, or develops acute complications in addition to, a chronic medical condition that would result in an acute hospitalization;

(c) the member has been discharged following a lengthy acute hospitalization and may be clinically unstable in the community. Before providing such services, the independent nurse must telephone the Division or its designee with information about the need for such additional services on a weekly basis; or

(d) the member meets the clinical criteria for nursing services and the primary caregiver is temporarily unavailable because he or she:

(i) has an acute illness or has been hospitalized;

(ii) has abandoned the member or has died within the past 30 days;

(iii) has a high-risk pregnancy that requires significant restrictions; or

(iv) has given birth within the four weeks prior to a request for additional services.

414.410: Multiple-Patient Care

(A) The Division pays for one nurse to provide nursing services simultaneously to more than one but not more than three members if:

(1) the members have been determined by the Division or its designee to meet the criteria listed at 130 CMR 414.408;

(2) the members will receive services in the same physical location and during the same time period;

(3) the independent nurse has determined that its safe and appropriate for one nurse to provide nursing services to the members simultaneously; and

(4) the independent nurse has received a separate prior-authorization approval for each member as described in 130 CMR 414.412.

(B) Services provided pursuant to 130 CMR 414.410(A) must be billed by using the multiple-patient service code that reflects the number of members receiving the services.

414.411: Case Management

The Division or its designee provides case management for complex-care members that includes service coordination with independent nurses as appropriate. The purpose of case management is to ensure that complex-care members are provided with a coordinated CLTC service package that meets such members' individual needs and to ensure that the Division pays for nursing and other CLTC services only if they are medically necessary in accordance with 130 CMR 450.204.

(A) DMA – Case Management Activities.

(1) Enrollment. The Division or its designee automatically enrolls members under the age of 22 who require a nurse encounter of more than two continuous hours of nursing, assigns such members a case manager, and informs the member of the name, telephone number, and role of the assigned case manager.

(2) Comprehensive Needs Assessment. The case manager may perform an in-person visit with the member, to evaluate whether the member meets the criteria to be a complex-care member as described in 130 CMR 414.402 and to complete a comprehensive needs assessment. The comprehensive needs assessment will identify, but may not be limited to identifying:

(a) services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community;

(b) services the member is currently receiving; and

(c) any other case management activities in which the member participates.

(3) Service Plan. The case manager:

(a) develops a service plan, in consultation with the member, the member's physician, the primary caregiver and, where appropriate, the home health agency that

(i) lists those MassHealth-covered services to be authorized by the case manager;

(ii) describes the scope and duration of each service;

(iii) lists service arrangements approved by the member or the member's primary caregiver; and

(iv) informs the member of his or her right to a hearing, as described in 130 CMR 414.413.

(b) provides to the member copies of the service plan, one copy of which the member or the member's primary caregiver must sign and return to the case manager. On the copy being returned, the member must indicate whether he or she accepts or rejects each service as offered and that he or she has been notified of the right to appeal and provided an appeal form;

(c) provides to the independent nurse information from the service plan that is applicable to the independent nurse.

(4) Service Authorizations. The case manager authorizes those CLTC services in the service plan, including nursing, that require prior authorization (PA) and that are medically necessary, as provided in 130 CMR 414.412, and coordinates all nursing services and any subsequent changes with the independent nurse.

(5) Discharge Planning. The case manager may participate in member hospital discharge planning meetings as necessary to ensure that medically-necessary CLTC services necessary to discharge the member from the hospital to the community are authorized and to provide all other identified third-party payers.

(6) Service Coordination. The case manager works with any other identified case managers for the member assigned to the member as may be identified during the comprehensive needs assessment other means.

(7) Case Manager Follow-up and Reassessment. The case manager provides ongoing case management for members and in coordination with the independent nurse to:

(a) determine whether the member continues to be a complex-care member; and

(b) reassess whether services in the service plan are appropriate to meet the member's needs.

(B) Independent Nurse — Case Management Activities.

(1) Service Plan. The independent nurse participates in the development of the service plan for each complex-care member, as described in 130 CMR 414.411(A)(3), in consultation with the case manager, the member, and/or the primary caregiver that:

(a) includes the appropriate assignment of nursing services; and

(b) incorporates full consideration of the member's and the caregiver's preferences for service arrangements.

(2) Coordination and Communication. The independent nurse closely communicates and coordinates with the Division's or its designee's case manager concerning the status of the member's nursing needs.

414.412: Prior Authorization

(A) General Terms.

(1) Prior authorization must be obtained from the Division as a prerequisite to payment for all nursing services. The Division bases its decision on the criteria set forth in 130 CMR 414.408. Prior authorization must be obtained from the Division before services are provided to the member. Without such prior authorization, services will not be reimbursed by the Division.

(2) Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.

(3) Approvals for prior authorization specify the number of hours for each service that are reimbursable each calendar week and the duration of the prior-authorization period. The authorization is issued in the member's name and specifies frequency and duration of care for each service approved per calendar week.

(4) Prior authorization for nursing services may be approved for more than one home health provider and/or independent nurse, provided that:

(a) each provider is authorized only for a specified portion of the member's total hours; and

(b) the sum total of the hours approved over the duration of the approved period do not exceed what the Division or its designee has determined to be medically necessary for the member.

(5) The independent nurse must complete the Request and Justification form for all non-complex-care members who require more than two continuous hours of nursing. The Request and Justification form must be signed and dated by the member's physician and submitted to the Division or its designee for review.

(6) The independent nurse may initiate the prior-authorization process by telephone or by submitting a completed prior-authorization request form to the Division or its designee. The independent nurse must submit all prior-authorization requests in accordance with the Division's billing instructions.
(7) If nursing services in excess of the authorized weekly amount are necessary, the independent nurse must contact the Division or its designee by telephone to request additional hours. The verbal request for additional hours must be followed up in writing within two calendar weeks of the verbal request.
(8) If there are unused hours of nursing services in a calendar week, they may be used at any time during the current authorized period.

(B) Complex Care Members.
(1) The independent nurse must obtain from the Division or its designee, as a prerequisite for payment, prior authorization for all nursing services provided to complex-care members.
(2) The independent nurse must refer potential complex-care members to the Division or its designee for a comprehensive needs assessment.
(3) If authorized services need to be adjusted because the complex-care member's medical needs have changed, the independent nurse must contact the Division or its designee by telephone to request an adjustment to the prior authorization.
(4) Any verbal request for changes in service authorization must be followed up in writing to the Division or its designee within two weeks of the date of the verbal request.

(C) Screening. The independent nurse must perform a screening of any member aged 22 or over who requires more than two continuous hours of nursing services and refer members under the age of 22 to the Division or its designee for case management.

414.413: Notification of Approval or Denial of Prior Authorization

(A) Notification of Approval. For all approved prior-authorization requests for nursing services, the Division or its designee sends written notice to the member and the independent nurse regarding the frequency, duration, and intensity of care authorized, and the effective date of the authorization.

(B) Notification of Denial or Modification and Right of Appeal.
(1) For all denied or modified prior-authorization requests, the Division or its designee notifies both the member and the independent nurse of the denial or modification, reason, right to appeal, and appeal procedure.
(2) A member may request a fair hearing from the Division if the Division or its designee denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 30 days after the date of the denial or modification. The Division's Board of Hearings conducts the hearing in accordance with 130 CMR 610.000.

(130 CMR 414.414 and 414.415 Reserved)

414.416: Overtime

(A) The Division pays an overtime rate for nursing services provided by an independent nurse only in the case of a documented emergency and for a short-term basis, not to exceed 30 consecutive calendar days, and when all of the following conditions are met:

(1) prior authorization for overtime has been obtained from the Division or its designee;
(2) nursing services are provided by the same independent nurse and exceed 40 hours in a given calendar week for the MassHealth member;
(3) documentation from a minimum of two home health agencies has been provided that demonstrates, to the satisfaction of the Division or its designee, that the independent nurse has attempted to find other nurses to fill the nursing hours that exceed 40 hours for the member; and
(4) the member meets any of the criteria listed in 130 CMR 414.409(L)(2).

(B) The Division or its designee does not approve requests for overtime as part of a routine submission for authorization for nursing services.

(C) In no event will any individual nurse be approved for a total of more than 60 hours of nursing care provided during any consecutive seven-day period.

414.417: Recordkeeping Requirements

(A) The record maintained by an independent nurse for each member must conform to the Division's administrative and billing regulations at 130 CMR 450.000. Payment for any service listed in 130 CMR 414.000 requires full and complete documentation in the member's health-care record. The independent nurse must maintain records for each member to whom nursing services are provided. Records must be maintained for at least six years after the date of service.

(B) In order for a health-care record to completely document a service to a member, the record must disclose fully the nature, extent, quality, and necessity of the care furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the Division may disallow payment (see the Division's administrative and billing regulations at 130 CMR 450.000).

(C) The independent nurse must maintain the health-care record using the problem-oriented system for recordkeeping. The health-care record must be reviewed and updated at least monthly by the independent nurse. The problem-oriented system for recordkeeping must contain at least the following:

(1) the member's name;
(2) a copy of the approved prior-authorization form;
(3) a data base, as defined at 130 CMR 414.402;
(4) a current nursing-care problem list, as defined at 130 CMR 414.402;
(5) a current nursing-care plan, as defined at 130 CMR 414.402; and
(6) nursing progress notes for each encounter, signed by the independent nurse, that includes the following information:
    (a) the full date of service;
    (b) a notation of the specific time that each shift both began and ended;
    (c) a current medication-administration sheet that includes the time of administration, drug identification and strength, route of administration, the member's response to the medication, and the signature of the person administering the medication;
    (d) a current treatment list or description of treatments administered, the time of administration, the member's response to the treatment, and the signature of the person administering the treatment;
    (e) the member's vital signs;
    (f) if the member's condition warrants, an intake and output record; and
    (g) any clinical tests and their results.

(D) The Division or its designee may request, and the independent nurse must furnish, copies of any and all health-care records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, s. 38 and 130 CMR 450.000.

(E) For members who are not complex-care members, the Request and Justification form, as defined at 130 CMR 414.402, must be signed by the member's physician, and submitted to the Division or its designee for prior authorization.

414.418: Maximum Allowable Fees

(A) The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for nursing services. The maximum allowable payment for a service is the lower of the following:

(1) the independent nurse's usual and customary fee; or
(2) the rate that DHCFP had established for that service.

(B) The payments made by the Division to the independent nurse constitute payment in full for nursing services as well as for all administrative duties relating to such services.

414.419 Denial of Services and Administrative Review

(A) A failure or refusal by an independent nurse to furnish services that have been ordered by the member's attending physician and that are within the range of reimbursable services is not an action by the Division or its designee that a member may appeal; but such failure or refusal constitutes a violation of these regulations for which administrative sanctions may be imposed. The Division will receive and act upon complaints from physicians, continuing-care coordinators, and other social-services agencies, as well as from members and their families. A failure or refusal by a physician to order services or to certify their medical necessity is not an action by the Division or its designee that a member may appeal.

(B) When an independent nurse believes that services ordered by the attending physician are not reimbursable under these regulations, the independent nurse must refer the matter to the Division for a payment decision. If and to the extent the Division determines that the ordered services are reimbursable, the independent nurse must provide those services.

REGULATORY AUTHORITY

130 CMR 414.000: M.G.L. c. 118E, ss. 7 and 12.

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